STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (2			(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DING	00	COMPLETED		
		155774	B. WIN			03/24/2	011	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	ROVIDER OR SUPPLIER	1			ICHIGAN AVENUE			
MILLEDIG	S MERRY MANOR			1	ISPORT, IN46947			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
F0000	This visit was for	r a Recertification and	F000	00				
	State Licensure.							
	Survey dates: Ma	arch 22, 23, & 24, 2011						
	Facility number:	012036						
	Provider number	: 155774						
	AIM number:	N/A						
	Survey Team:							
	Angela Strass, R	N_TC						
	Julie Wagoner: RN							
	Tim Long, RN							
	Census bed type:							
	SNF: 14	•						
	Total: 14							
	Census payor typ	ne.						
	Medicare: 14							
	Total: 14							
	10tal. 14							
	Sample: 8							
		es also reflect state						
	findings cited in	accordance with 410 IAC						
	16.2.							
	Ouality review o	ompleted on March 28,						
	2011 by Bev Fau	•						
	2011 by Dev Fau							
LABORATOR	Y DIRECTOR'S OR PROV	/IDER/SUPPLIER REPRESENTATIVE'S SIC	NATURE		TITLE		(X6) DATE	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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Event ID:

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Facility ID:

012036

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155774	(X2) M A. BUII B. WIN	LDING	ONSTRUCTION 00	(X3) DATE COMPI 03/24/2	LETED
	PROVIDER OR SUPPLIER			1101 M	ADDRESS, CITY, STATE, ZIP CODE ICHIGAN AVENUE ISPORT, IN46947		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΛΤΕ	DATE

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Event ID:

XPR711

Facility ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155774	B. WIN			03/24/2	011
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	-		1101 M	IICHIGAN AVENUE		
	MERRY MANOR		_		NSPORT, IN46947		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION DATE
TAG		LSC IDENTIFYING INFORMATION)	F02/		F 226 No other residents have		
F0226		review and interview,	F022	26	been affected by this deficient		04/23/2011
SS=D	•	to follow their policy			practice. Moving forward a		
		entation from witnesses			summary will be compiled by the		
	•	ed allegations of abuse			Administrator or designee at th	е	
	reviewed. This is	nvolved Resident #15.			conclusion of all abuse		
	Finding Includes	:			investigations including, but no limited to, statements from involved parties. This follows the Facility Abuse Policy and		
	On 3/23/11 at 10	0:00 a.m., review of a			Procedure protocol. All abuse	е	
	reported incident	, dated 1/26/11, indicated			investigations will be reviewed	by	
	•	ted "That staff member			Quality Assurance Nurse or designee to ensure that abuse		
	put her hand over my mouth and squeezed my cheeks."				investigation policy is being		
					followed. Furthermore, educat	ion	
	my enecks.				on the facility Abuse Policy and		
	On 3/23/11 at 2:30 p.m., the administrator				/ ·Iv		
	was asked for the	e investigation and			April 22, 2011 and then quarter for all staff. All corrections will		
	provided a writte	en summary as follows:			completed by April 23, 2011.Addendum: Quality		
	-	g an investigation of the			Assurance audits will be completed on any unusual		
		, it was determined that			occurance weekly for 8		
	_	ent was not abusive in			weeks, and then Monthly per the QA program to ensure	ie	
		trator and Director of			compliance.		
		ed interviews with			F		
		ll having the same story					
	_	ent was counting out					
	another resident's	s exercises and the					
	therapist touched	her cheeks in a joking					
	manner as if they	were close friends. An					
	interview was als	so conducted with the					
	resident involved	l; who stated that the					
	actions of the the	erapist shocked her but					
	did not harm her.	. It was conclusive that					
	all parties involv	ed did not believe this					
	-	ive. The specific					
					•		

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Event ID: XPR711 Facility ID: 012036

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DIIII	A. BUILDING 00			COMPLETED	
		155774				- 03/24/2011		
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF I	PROVIDER OR SUPPLIE	R			IICHIGAN AVENUE			
	S MERRY MANOR			1	NSPORT, IN46947			
IVIILLER	5 WERRT WANDR		_	LOGAN				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	*	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP	E RIATE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	employee was s	uspended during the						
	investigation pro	ocess and was disciplined						
	for her actions.	All staff has been						
		e importance of reporting						
	possible abuse a							
	possible abuse a	negations.						
	0 2/24/11 + 2	00 1 1 1 1 1 1 1						
		00 p.m., the administrator						
	was asked if the	re were written statements						
	by the witnesses	and he indicated "no."						
	He stated that th	e risk management team						
	has them shredd							
	Review of the fa	acility policy for Abuse						
		porting and Investigation,						
	dated 3/8/10, inc	dicated the following:						
	"A comprehensi	ve record of all abuse						
	investigations is	to be compiled and kept						
	by the facility, in	ncluding but not limited						
	1 .	orts, statements from						
		thers involved, reports,						
	1	and all other relevant						
	information."							
	3.1-28(a)							

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLETED		
		155774	B. WIN			03/24/201	1	
NAME OF E	PROVIDER OR SUPPLIER		-	STREET	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF F	ROVIDER OR SUFFLIER			1101 M	IICHIGAN AVENUE			
	S MERRY MANOR			LOGAN	NSPORT, IN46947			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ε (COMPLETION	
TAG	1	LSC IDENTIFYING INFORMATION)	700	TAG	ļ		DATE	
F0272		review and interviews,	F02'	/2	No other residents were affected by this deficient practice. All	ea 10	04/23/2011	
SS=D	the facility failed	to assess a resident's			nurses will be in-serviced on			
	response to the re	emoval of a urinary			completing the Catheter			
	catheter for 1 of i	residents reviewed for			(Anchored) Removal/Insertion			
	incontinence in a	sample of 10. (Resident			Assessment upon the removal	of		
	#14) In addition.	, the facility failed to			any Anchored Catheters. All			
		of a urinary tract			nurses will be in-serviced on			
	, ,	2 residents reviewed for			completing the Infections Assessment every shift for all			
		mple of 10. (Residents			residents on an Antibiotic. The	se		
	#13 and #7)	imple of 10. (Residents			In-services will be completed b	I .		
	#15 and #7)				April 22, 2011. Director of			
	Findings include:				Nursing or Designee will			
					complete a Catheter Removal	_		
					Review with Physicians Order	for		
	1. The clinical re	ecord for Resident #13			Removal of Catheter. (Attachment A) Director of			
	was reviewed on	03/22/11 at 2:15 P.M.			Nursing or Designee will			
	Resident #13 was	s admitted to the facility			complete an Infection			
	on 03/03/11 from	an acute care facility			Assessment Review daily			
	with diagnosis, in	ncluding but not limited			Monday through Friday for 4			
	to diverticulitis o	_			weeks, then weekly for 4 week			
					then monthly for 4 months ther	1		
	The admission of	hysician orders, dated			quarterly with our QA tool. (Attachment B) All Correction	,		
	03/03/11 included	,			will be completed by April 23,	Ğ		
					2011 Addendum: QA tools will	be		
	1	to be given for 5 days.			monitored and evaluated by			
	1 1 1	ysician's order, dated			Quality Assurance team weekly	/		
		antibiotic, Zithromax was			for 8 weeks then			
	also received.				Monthly thereafter. Findings wi be corrected upon discovery as			
					a summary will be reported at t			
	There was no ass				monthly QA Comittee Meeting			
	documentation, f	rom 03/03/11 - 03/07/11			ensure compliance.			
	regarding any sig	gns and/or symptoms of						
		kind for Resident #13.						
	1	re was an assessment						
	· ·	nd/or symptoms of a						
		nd/or symptoms of a ction for Resident #13						

NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG (EACH DEFICIENCY MUS		NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155774	ĺ	LDING	NSTRUCTION 00	(X3) DATE COMPI 03/24/2	LETED
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) documented. Interview with the Director of Nursing, on 03/23/11 at 11:15 A.M., indicated the previous facility had sent a urinalysis laboratory test on 03/03/11 prior to the resident's discharge and admission to this facility. She indicated she thought the Septra was ordered to treat a possible urinary tract infections. She indicated that on 03/07/11 the facility faxed the physician due to the dark color of Resident #13's urine and the physician ordered the Zithromax. She confirmed there was no assessment of any signs and/or symptoms specific to a urinary tract infection documented until 03/08/11. 2. The clinical record for Resident #14 was reviewed on 03/23/11 at 10:00 A.M.					1101 MI	CHIGAN AVENUE	1	
Interview with the Director of Nursing, on 03/23/11 at 11:15 A.M., indicated the previous facility had sent a urinalysis laboratory test on 03/03/11 prior to the resident's discharge and admission to this facility. She indicated she thought the Septra was ordered to treat a possible urinary tract infections. She indicated that on 03/07/11 the facility faxed the physician due to the dark color of Resident #13's urine and the physician ordered the Zithromax. She confirmed there was no assessment of any signs and/or symptoms specific to a urinary tract infection documented until 03/08/11. 2. The clinical record for Resident #14 was reviewed on 03/23/11 at 10:00 A.M.	PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR		COMPLETION
from an acute care facility on 03/12/11, with diagnosis including, but not limited to; pneumonia, Alzheimer's dementia, and urinary retention. The initial admission assessment, completed on 03/12/11 at 14:30 (2:30 P.M.), indicated the resident had an indwelling urinary catheter. A physician's order, dated 03/18/11, was received to remove and discontinue the urinary catheter. There was no assessment or documentation regarding the removal of the resident's catheter and	TAG	documented. Interview with the 03/23/11 at 11:11 previous facility laboratory test or resident's dischate facility. She ind Septra was order urinary tract inferon 03/07/11 the physician due to Resident #13's urinary tract inferon or assessment, and an indwelling to physician due to Resident #14 was reviewed on Resident #14 was reviewed on Resident #14 was from an acute care with diagnosis in to; pneumonia, Arurinary retention assessment, com 14:30 (2:30 P.M. had an indwelling track assessment or documents of the control of t	ne Director of Nursing, on 5 A.M., indicated the had sent a urinalysis in 03/03/11 prior to the rege and admission to this icated she thought the red to treat a possible actions. She indicated that facility faxed the the dark color of rine and the physician romax. She confirmed ressment of any signs is specific to a urinary ocumented until 03/08/11. Becord for Resident #14 103/23/11 at 10:00 A.M. is admitted to the facility, re facility on 03/12/11, including, but not limited Alzheimer's dementia, and in The initial admission pleted on 03/12/11 at indicated the resident g urinary catheter. Ber, dated 03/18/11, was ove and discontinue the There was no ocumentation regarding		TAG	DEFICIENCY)		DATE

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPI		
		155774	B. WIN	IG		03/24/2	2011	
NAME OF F	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE			
MILLER'S	MILLER'S MERRY MANOR		1101 MICHIGAN AVENUE LOGANSPORT, IN46947					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR		COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	response to the r	emoval documented.	Ī					
	Interview with the	he Director of Nursing, on						
	03/23/11 at 1:30	P.M., indicated the only						
	documentation v	vas a daily assessment						
	which marked, "	abdomen not distended"						
	and a 3 day void	ling pattern which						
	indicated the res	ident had been						
	incontinent of u	rine on 03/18/11 at 4:00						
	P.M. and voided	l in the toilet on 03/18/11						
	at 6:00 P.M.							

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155774 03/24/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1101 MICHIGAN AVENUE MILLER'S MERRY MANOR LOGANSPORT, IN46947 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE F 333 No other residents were F0333 Based on record review and interviews, F0333 04/23/2011 affected by this deficiency; no the facility failed to ensure medications SS=D residents were harmed by this were given as prescribed in order to deficiency. No negative promote treatment of respiratory outcomes noted because of this deficient practice. All conditions, bladder control and infections transcription errors were for 3 of 10 residents reviewed for immediately corrected upon medication orders in a sample of 10. finding. All Nurses will be (Residents #7, 12, and 14) in-serviced on New Orders Verbal/ Telephone Policy, All Nurses will be in-serviced on the Findings include: Medications available in the Pyxis Medication Distribution 1. The clinical record for Resident #12 Machine. All Nurses will be was reviewed on 03/24/11 at 9:30 A.M. In-serviced by April 22, 2011. Director of Nursing or Resident #12 was admitted to the facility Designee will perform Medication on 03/21/11 with diagnosis, including but Transcription Administration Audit not limited to, bronchitis and chronic daily for 4 weeks, weekly for 4 weeks, monthly for 4 months, obstructive pulmonary disease (COPD). then quarterly. (Attachment C) All corrections will be in place by The admission orders included orders for April 23, 2011, Addendum: QA the resident to receive Duoneb respiratory tools will be monitored and treatments QID (four times a day) and evaluated by Qualtiy Assurance team weekly for 8 weeks then PRN (as needed). monthly thereafter. Findings will be corrected upon discovery and Review of the Medication Administration a summary will be reported at the Record (MAR) for March 2011 indicated monthly QA meeting to ensure compliance. the resident did not receive the first dose of Duoneb treatment until 6:00 A.M. on 03/22/11. There was no documentation beside the 4:00 and 9:00 P.M. scheduled doses of Duoneb to indicate why the resident did not receive the medication. Review of the admission assessment, completed on 03/21/11, indicated the

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED	
		155774	B. WIN			03/24/2	011
			D. ((1)		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			1	ICHIGAN AVENUE		
MILLER'S	S MERRY MANOR			1	ISPORT, IN46947		
				<u>.</u>			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG	\	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENC!)		DATE
		nitted to the facility at					
	4:00 P.M. and wa	as assessed to have					
	"wheezes" in her	breath sounds.					
	Review of the fa	cility list of medications					
		mergency Medication					
	Kit, included bot	U ,					
		nedications, Albuterol and					
	1 ^ ^	mide, the generic names					
	for the medication	ons in Duoneb.					
	Interview with th	ne Director of Nursing					
	(DN), on 03/24/1	1 at 2:00 P.M., indicated					
	she did not know	why the medications					
		d from the pharmacy or					
		rug kit and administered.					
		aps the nurse was					
	_	eneric name for the					
	medications.						
	Review of the nu	irse's notes for 03/21/11					
	and 03/22/11 ind	icated there was no					
	documentation re	egarding the inability to					
		cations timely for					
		addition, Resident #12					
		order, dated 03/23/11 at					
	1 .						
		ange the strength of					
		od thinner) and new					
		amins, Iron and C. Both					
	Vitamins were or	ders to be given on a					
	daily basis.						
	Review of the M	arch 2011 MAR					
		ength of the Coumadin					
	I marcated the stre						

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155774	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	` ′	E SURVEY PLETED 2011
	PROVIDER OR SUPPLIER		1101 MI	DDRESS, CITY, STATE, ZIP CO ICHIGAN AVENUE SPORT, IN46947	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	but the addition and the Vitamin the MAR and had on 03/24/11. Into of Nursing, on 0 indicated she had and she had "mis Vitamin C and the 2. The clinical rewas reviewed on Resident #14 wad on 03/12/11, with not limited to propose a day for 100 mg (a medic control). There we on the Ditropantal Review of the Madministration Indicated the Ditarecord and had record and had record and had not 6:00 P.M., on 03 accurately rewrited.	d to reflect the new order, of the Iron Supplement C had not been placed on ad not been administered erview with the Director 3/24/11 at 2:00 P.M., d spoken with LPN #1 seed" the new orders for a Iron supplement. ecord for Resident #14				

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	L DI	I DDIC	00	COMPI	LETED
		155774	B. WIN	LDING		03/24/2	.011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER	L			ICHIGAN AVENUE		
MILLEDIG	S MERRY MANOR			1	ISPORT, IN46947		
	3 WERRT WANCK			LOGAN			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΙΤΕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	missed 4 doses o	f medication.					
	Review of the fa	cility list of medications					
		Emergency Medication					
	Kit, included bot	• •					
	· ·	nedications, Albuterol and					
		· · · · · · · · · · · · · · · · · · ·					
	1 * *	mide, the generic names					
	for the medication	ons in Duoneb.					
	Interview with th	ne Director of Nursing, on					
	03/24/11 at 2:00	P.M. indicated she did					
	not know why th	e medications were not					
	1	e pharmacy or the					
		kit and administered prior					
		_					
		thought perhaps the					
		are of the generic name					
	for the medication	ons. She indicated the					
	Ditropan order h	ad been "missed" when					
		admitted to the facility.					
		-					
			ı				I

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED	
		155774	B. WING			03/24/2	011
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				IICHIGAN AVENUE		
MILLER'S	S MERRY MANOR				NSPORT, IN46947		
		TATEMENT OF DEPLOYENCIES					are)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	DATE
	1	· · · · · · · · · · · · · · · · · · ·	F037		F 371 Millers Merry Manor has		
F0371		ation, and interviews, the	FU3/	1	systems in place and has police		04/23/2011
SS=F	_	ensure 2 of 2 cooks			and for food procurement/		
		ng food did not touch			sanitation. This policy and		
	food directly with	h contaminated gloves.			procedure is in accordance with	h	
	(Cook #1 and 2)	This actually affected 7			State and Federal Law.This		
	of 14 meals obse	rved being prepared and			deficiency potentially could have		
		red 14 of 14 residents			affected all residents that resident the facility during survey.	ea	
	•	ood prepared in the			Cooks #1 and #2 were		
	kitchen.	o a propulsa in inc			immediately in-serviced on pro	per	
	Kitchen.				glove use on 3-22-11. To ensu		
	Einding inglydge				that this deficiency does not		
	Finding includes	•			occur, all Cooks and salad		
					positions were in-serviced on		
	_	servation of the meal			proper glove use on 3-28-11.		
	preparation for the	ne noon meal, on			Additionally all cook, and salad positions were in-serviced on		
	03/22/11 between	n 12:00 - 12:15 P.M., the			proper use of tongs on		
	following was no	oted during the			4-8-11. Additional sanitation		
		of the 14 meals for			in-services will be given to cool	k	
		ong term care unit:			and salad positions monthly.		
		iong term oure unit.			skills checklist will be used with	1	
	Cook #1 weehed	har hands dannad a nair			cook and salad positions to		
		her hands, donned a pair			ensure proper glove and tong		
		ves, picked up an aerosol			use. (Attachment D) Monitoring the effectiveness of these	ıg	
		cooking spray and			systems will be done by Weekl	v	
	sprayed the grill,	then touched the			sanitation checklists (Attachme	•	
	refrigerator door	handle, opened plastic			E) done by dietary manager of		
	wrap and reached	d in a handled two			designee, for one month, then	bi	
	hamburger pattie	s directly with her soiled			monthly for one month then		
	~ .	cing the hamburgers on			monthly there after. These		
		oved her gloves, washed			sanitation check lists will be		
	_	onned a clean pair of			reviewed by Logansport's Certified Dietary Manager upor	,	
		-			completion. Registered Dietitia		
	-	rearranged paper order			will perform spot checks in the		
	_	loved hands, then			kitchen at each scheduled visit		
		g tray, touched the			(two times monthly) for the nex		
	_	and handle, reached in			weeks to monitor compliance.		
	the refrigerator a	nd obtained a handful of			any issues are found during the	9	

XPR711

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155774	A. BUILDING	OO	COM	TE SURVEY MPLETED 1/2011
			B. WING	ET LDDDDGG CITY CTLTE GID		
NAME OF F	PROVIDER OR SUPPLIER	8	l l	ET ADDRESS, CITY, STATE, ZIP (MICHIGAN AVENUE	CODE	
MILLER'S	S MERRY MANOR			GANSPORT, IN46947		_
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	E APPROPRIATE	COMPLETION DATE
IAG		LSC IDENTIFYING INFORMATION)	IAG	audits; a repeat audit	will be done	DATE
		her contaminated gloved		the following day.		
	1 ^	placed and arranged the		corrections will be in p	place by	
		etly with both of her		April 23, 2011.Addend		
		aking tray and placed the		Sanitation checks will monitored by by QA c		
	I -	n. After again removing		weekly for 8 weeks th		
	1 ~	vashing her hands, Cook		thereafter. Findings v		
		er pair of gloves. She		corrected upon discov		
		oth of there gloved hands,		summary will be report		
		ides and sides of two		monthly QA comittee ensure compliance.	meeting to	
		ive ovens, handled the		oneard compliance.		
		frigerator door, and then				
		refrigerator and grabbed a				
		en nuggets directly with				
	I -	aminated hands. She				
	l -	en nuggets into a deep				
	1 *	e then touched the outside				
		, again rearranged paper				
	orders, touched t					
		in, and then obtained a				
		m the refrigerator				
		es and edges with her				
	1	oved hands. Cook #1				
	continued to touc					
		appers, handles, and				
		lices, buns, and bread				
	directly with con	taminated gloved hands.				
		her hands and donned a				
	pair of disposabl	e gloves, touched the				
	outsides of two s	stacked microwaves,				
	touched the outsi	ide of a plastic bag,				
	reached in and di	irectly handled sliced				
	turkey meat. Aft	ter preparing the turkey				
	meat in a bowl, t	he cook removed her				
FORM CMS-2	2567(02-99) Previous Version	ons Obsolete Event ID:	XPR711 Faci	ility ID: 012036 If co	ontinuation sheet	Page 13 of 20

PRINTED: 04/19/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING 00		COMPLETED			
		155774	B. WING	03/24/2011				
NAME OF BROWNER OF GUIDNIER			STREET	ADDRESS, CITY, STATE, ZIP CODE				
NAME OF PROVIDER OR SUPPLIER			1101 MICHIGAN AVENUE					
MILLER'S MERRY MANOR			LOGANSPORT, IN46947					
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)			
PREFIX	·	ICY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI				
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE			
	l -	ed her hands. After						
	ı ~	pair of gloves, the cook						
		ide of a bread wrapper						
	and reached in w	vith her contaminated						
	gloved hands and	d directly obtained sliced						
		hing her hands again and						
	donning another	pair of gloves, the cook						
		the outside of the						
	microwave, bowls, food order paper tickets, wrappers, and the refrigerator							
	door and reached in an directly handled a piece of cheese, which was placed on top							
	1 *	1 1						
	of food in a bow	1.						
	Interview with th	ne Food Service						
	Supervisor on 03	3/21/11 at 12:15 P.M.,						
	indicated the foo	od for long term care						
	facility floor resi	idents was prepared at the						
	1 *	the resident by Cooks #1						
		ividual basis. She did not						
		ent regarding the concern						
	1 -	ndling by Cook #1 and						
		nding by Cook #1 and						
	#2.							
	2.1.21(3)(2)							
	3.1-21(i)(2)							
	I		1	1	ı			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

XPR711 Facility ID:

012036

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			l	COMPLETED	
		155774	B. WIN			03/24/20	11	
NAME OF E	PROVIDER OR SUPPLIER		-	STREET.	ADDRESS, CITY, STATE, ZIP CODE			
While of TROVIDER OR SOTTELLR			1101 MICHIGAN AVENUE					
MILLER'S MERRY MANOR				LOGAN	NSPORT, IN46947			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		TE	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		_	TAG	DEFICIENCY)		DATE	
F0425		review and interviews,	F042	25			04/23/2011	
SS=D	1	to ensure medications			affected by this deficiency; no residents were harmed by this			
	were obtained an	d administered timely for			deficiency. No negative			
	3 of 10 residents	reviewed for medication			outcomes came out because o	f		
	orders in a sampl	e of 10. (Residents #7,			this deficiency. All transcription	า		
	12, and 14")				errors were immediately			
					corrected upon finding. All Nurs			
	Findings include:	:			Verbal/ Telephone Policy. All			
	1. The clinical record for Resident #12 was reviewed on 03/24/11 at 9:30 A.M.				Nurses will be in-serviced on the	ne		
					Medications available in the Py	xis		
					Medication Distribution			
		s admitted to the facility			Machine. All Nurses will be in-serviced on the In touch			
	on 03/21/11 with diagnosis, including but not limited to, bronchitis and chronic obstructive pulmonary disease (COPD). The admission orders included orders for the resident to receive Duoneb respiratory				Medication ordering and receiv	_{rina}		
					from Pharmacy Policy and			
					Procedure. All Nurses will be			
					In-serviced by April 22,			
					2011. Director of Nursing or Designee will perform Medicati	on		
					Transcription Administration Au			
					daily for 4 weeks, weekly for 4			
treatments QID (four times a day) at PRN (as needed).		• /			weeks, monthly for 4 months,			
		•			then quarterly. All corrections			
	Davious of the M	edication Administration			will be in place by April 23, 2011.Addendum: QA tools will	_{be}		
					monitored and evaluated by			
` '		or March 2011 indicated			Quality Assurance team weekly	/		
		not receive the first dose			for 8 weeks then			
		nent until 6:00 A.M., on			Monthly thereafter. Findings wi be corrected upon discovery as			
	03/22/11. There was no documentation				a summary will be reported at t			
		nd 9:00 P.M. scheduled			monthly QA comittee meeting t			
		to indicate why the			ensure compliance.			
	resident did not r	eceive the medication.						
		mission assessment,						
		/21/11, indicated the						
		nitted to the facility at						
	4:00 P.M. and wa	as assessed to have						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING 00 COM				PLETED	
		155774	B. WIN			03/24/2	011	
NAME OF I	PROVIDER OR SUPPLIEF	}	•		ADDRESS, CITY, STATE, ZIP CODE	•		
MILLER'S MERRY MANOR					ICHIGAN AVENUE ISPORT, IN46947			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		\neg	ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENCY)		DATE	
	"wheezes" in her breath sounds.							
	Review of the faincluded in the EKit, included both bronchodilator in Ipratropium Bronfor the medication. Interview with the on 03/24/11 at 2 did not know who not obtained from the emergency drug. She thought perhunaware of the generations. Review of the interview of the interview with the medications. Review of the interview of the intervie	cility list of medication Emergency Medication th respiratory nedications, Albuterol and mide, the generic names ons in Duoneb. the Director of Nursing, 200 P.M., indicated she may the medications were in the pharmacy or the kit and administered. The pharmacy of the way the nurse was generic name for the nurse was generic name for the nurse was no egarding the inability to cations timely for						
		ot been administered on						
	03/24/11. Interview with the Director of							

NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG NUTSing, on 03/24/11 at 2:00 P.M., indicated she had spoken with LPN #1 and she had "missed" the new orders for Vitamin C and the Iron supplement. 2. The clinical record for Resident #14 was reviewed on 03/23/11 at 10:00 A.M. Resident #14 was admitted to the facility, on 03/12/11, with diagnosis, including but not limited to pneumonia and COPD. The admission physician orders, included orders for the medication, Duoneb (a bronchodilator)to be given QID (four times a day) for 5 days. Review of the March 2011 MAR indicated the Duoneb was documented as not having been administered until 6:00 P.M. on 03/13/11. The resident missed 4 doses of Duoneb.	I '		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	INSTRUCTION 00	(X3) DATE S COMPL	
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR (X4) ID (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Nursing, on 03/24/11 at 2:00 P.M., indicated she had spoken with LPN #1 and she had "missed" the new orders for Vitamin C and the Iron supplement. 2. The clinical record for Resident #14 was reviewed on 03/23/11 at 10:00 A.M. Resident #14 was admitted to the facility, on 03/12/11, with diagnosis, including but not limited to pneumonia and COPD. The admission physician orders, included orders for the medication, Duoneb (a bronchodilator) to be given QID (four times a day) for 5 days. Review of the March 2011 MAR indicated the Duoneb was documented as not having been administered until 6:00 P.M. on 03/13/11. The resident missed 4							1	
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CX4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG	NAME OF P	ROVIDER OR SUPPLIER			1			
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bronchodilator)to be given QID (four times a day) for 5 days. Review of the March 2011 MAR indicated the Duoneb was documented as not having been administered until 6:00 P.M. on 03/13/11. The resident missed 4		1						
Review of the March 2011 MAR indicated the Duoneb was documented as not having been administered until 6:00 P.M. on 03/13/11. The resident missed 4		orders for the me	edication, Duoneb (a					
Review of the March 2011 MAR indicated the Duoneb was documented as not having been administered until 6:00 P.M. on 03/13/11. The resident missed 4		bronchodilator)to be given QID (four						
indicated the Duoneb was documented as not having been administered until 6:00 P.M. on 03/13/11. The resident missed 4		times a day) for 5 days.						
indicated the Duoneb was documented as not having been administered until 6:00 P.M. on 03/13/11. The resident missed 4		Review of the M	arch 2011 MAR					
not having been administered until 6:00 P.M. on 03/13/11. The resident missed 4								
P.M. on 03/13/11. The resident missed 4								
		_						
Review of the facility list of medication		Review of the facility list of medication						
included in the Emergency Medication		included in the E	mergency Medication					
Kit, included both respiratory								
bronchodilator medications, Albuterol and								
Ipratropium Bromide, the generic names			_					
for the medications in Duoneb.		for the medicatio	ons in Duoneb.					
Interview with the Director of Nursing,		Interview with the	he Director of Nursing					
on 03/24/11 at 2:00 P.M., indicated she			•					
did not know why the medications were								
not obtained from the pharmacy or the			-					
Emergency Drug Kit and administered								
prior to 03/13/11. She thought perhaps								

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STATEMENT OF DEFICIENCIES X		X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	TIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF CORRECTION IDENT		IDENTIFICATION NUMBER:	A. BUILI	MMC	00	COMPI	ETED
155774		B. WING 03/24/2011			011		
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR			p. wind	1101 M	ADDRESS, CITY, STATE, ZIP CODE ICHIGAN AVENUE ISPORT, IN46947	1	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	VI E.	DATE
·	the nurse was ur	naware of the generic					
	name for the me	dications.					
	Review of the fa	acility policy and					
	procedure, titled						
	1 ~	_					
		cations From Pharmacy"					
	indicated the following: "3. New						
	•	cept for emergency or					
	"stat" medication	ns, are ordered as follows:					
	a) If needed bef	Fore the next regular					
	delivery, phone	the order to pharmacy					
	immediately upo	on receipt. Inform					
	1	need for prompt delivery					
	1 ^	very within (4) hours. b)					
		of new orders is required					
		on administration is not					
	1 -	nergency kit is used when					
		ds a medication prior to					
	pharmacy delive	ery"					

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Event ID:

XPR711

Facility ID: 012036

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PF		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE		(X3) DATE S	ATE SURVEY		
AND PLAN OF CORRECTION IDEN		IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLI	ETED	
		155774	B. WING 03/24/2011			011		
NAME OF B	DOLUMBER OR GUIRRU IER				ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	ROVIDER OR SUPPLIER		1101 MICHIGAN AVENUE					
MILLER'S MERRY MANOR					ISPORT, IN46947			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX TAG		CY MUST BE PERCEDED BY FULL	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE	
	REGULATORY OR LSC IDENTIFYING INFORMATION)		F051		F 514 No other residents were			
F0514		review and interviews,	1 5031	4	affected by this deficiency; no	04/23/2011		
SS=D	_	to ensure medication			residents were harmed by this			
		scribed accurately for 2 of			deficiency. No negative		1	
		ewed for medication			outcomes noted from deficient			
	•	le of 10. (Residents # 12			practice. All transcription error were immediately corrected up			
	and 14)				finding. All Nurses will be			
	Findings include: 1. The clinical record for Resident #12 was reviewed on 03/24/11 at 9:30 A.M. Resident #12 was admitted to the facility on 03/21/11 with diagnosis, including but not limited to, bronchitis and chronic obstructive pulmonary disease (COPD). A physician's order, dated 03/23/11 at 5:00 P.M., to change the strength of Coumadin (a blood thinner) and new				in-serviced on New Orders Verbal/ Telephone Policy. All Nurses will be In-serviced by A	\pril		
					22, 2011. Director of Nursing o			
					Designee will perform Medicati			
					Transcription Administration Au daily for 4 weeks, weekly for 4	iait		
					weeks, monthly for 4 months,			
					then quarterly. All Corrections	will		
					be in place by April 23,			
					2011.Addendum: QA tools will be monitored and evaluated by Quality Assurance team weekly			
					for 8 weeks then			
					Monthly thereafter. Discoveries will be corrected immediatly an			
		amins, Iron and C was			summary will be reviewed at th			
	received. Both v	ritamins were orders to be			monthly QA comittee meeting t			
		basis. Review of the			ensure compliance.			
	_	R indicated the strength						
		had been changed to						
		rder, but the addition of						
		nent and the Vitamin C						
		ced on the MAR and had						
	-	stered on 03/24/11.						
		ne Director of Nursing, on						
		P.M. indicated she had						
	spoken with LPN							
	-	orders for Vitamin C						
	and the Iron supp							
	and the from supp	AVIIIVIII.						

PRINTED: 04/19/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	L DIII	DING	00	COMPLETED	
		155774	A. BUILDING B. WING			03/24/2011	
			STREET ADDRESS, CITY, STATE, ZIP CODE				
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 MICHIGAN AVENUE				
MILLEDIO	S MERRY MANOR			1			
				LOGANSPORT, IN46947			
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG	\	R LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
		record for Resident #14					
	was reviewed or	n 03/23/11 at 10:00 A.M.					
	Resident #14 wa	as admitted to the facility,					
	on 03/12/11, wit	th diagnosis, including but					
		neumonia and COPD. The					
		cian orders, included an					
		dication, Ditropan xl 100					
		n to increase bladder					
	control). There was no frequency ordered						
	on the Ditropan	order.					
	Review of the M	March 2011 MAR					
		tropan was not on the					
	record and had r	not been administered.					
	Interview with the	he Director of Nursing, on					
	03/24/11 at 2:00	P.M., indicated she did					
		ne medications were not					
	1	mented on the March 2011					
	I	cated the Ditropan order					
		ed" when the resident was					
	admitted to the f	iacinty.					
	3.1-50(a)(1)						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

XPR711

Facility ID:

012036

If continuation sheet